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ABSTRACT

A central question to evaluative research at all levels is, Who should do it? In evaluating drug abuse programs three groups might be involved: treatment personnel, administrative or research personnel, and outside research professionals. This paper presents some advantages and disadvantages to the involvement of each of these groups within the context of five core dimensions: design bias, response bias, trust and access, expertise, and experimental control. At the Veterans Administration Hospital in Palo Alto, California, a team with representatives from each of three personnel groups is evaluating the drug abuse treatment programs. We believe this model allows us to maximize the advantages and minimize the disadvantages of each group's involvement in evaluative research. (Author/MLP)

PROGRAM EVALUATION: WHO SHOULD DO IT?

Richard N. Bale

The last five years have seen an exponential growth in the evaluation of mental health programs. More recently drug abuse treatment programs have been the subject of intensive evaluation and follow-up efforts. Large scale outcome research efforts are being carried out by the National Institutes of Mental Health and the Special Action Office for Drug Abuse Prevention. Last month the Veterans Administration launched a full scale follow-up study of patients entering its drug dependent treatment centers, a project described in another paper on this panel.

Concurrent with these national efforts are a number of local and regional efforts at evaluating drug abuse programs. A central question to evaluative research at all levels (and still an unanswered one for the follow-up component of the national VA study) is, put most simply, who should do it? That is, what group or agency should be responsible for the design, planning and execution of valid and useful evaluative studies?

There are three principal groups that might be involved in evaluative research. These are:

1. The *treatment personnel* themselves. Those who perform or are directly responsible for the therapeutic activities of the treatment program.

2. *Administrative or research personnel.* Co-workers at the same institution, but who have no direct clinical role in the program.

3. *Outside research professionals.* Little or no previous or continued contact with the treatment program and personnel, contracted to perform evaluation.

There are several advantages and disadvantages in the involvement of each of these principal groups in evaluative research. I shall outline these considerations in the context of five core dimensions of evaluative studies.

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Design Bias. Each group brings to the research design an understandably different bias. Responding to their own need for survival, treatment personnel will tend to choose the outcome parameters sensitive to positive changes on the part of their patients. The more secure programs open to process change are likely to design evaluative research which can be used in a diagnostic way to improve program weaknesses. The parameters in either case may or may not coincide with those criteria used by the other two groups.

Non-treatment personnel may respond to their own or other outside interests, e.g. congressional inquiries, funding agencies, etc. These interests may be manifested in a set of outcome criteria that may not coincide with the explicit or implicit goals of the treatment personnel. This is a common occurrence in drug program evaluation where outside evaluators may choose a set of crime-related criteria while the treatment personnel are more concerned with psychological changes. When there exist wide discrepancies between criteria, programs may wittingly or unwittingly undermine evaluation efforts by outside personnel.

Related to discrepancies in criteria are differences in the use made of research results. Treatment personnel often believe (and often rightly) that decisions based on research results will be selective rather than diagnostic. That is, a broad decision will be made to retain or discontinue a program rather than to improve it. In such cases the program of course has nothing to *gain* (other than continued existence) by participating in research.

Response Bias. Both researcher and subject may wittingly and unwittingly contribute to bias in responses to research instruments. The problems of experimenter bias have been thoroughly reviewed by Rosenthal (1). Treatment personnel will tend to interpret responses to a subjective question ("how are you getting along with your family?") in a positive direction. But it is also not unreasonable to suspect that outside evaluators, who may profit from positive results in future contracts, may experience subtle pressure to bias their judgments. Local researchers on staff with the treatment personnel may experience similar pressure to positively bias results, in order to retain programs which can be further researched.

Respondents may carry a wide variety of hidden agendas to the interview (or other research) situation. An "unsuccessful" ex-patient may be honest to treatment personnel to whom he can return for help; however, the same ex-patient may seek to protect the program by presenting himself to outside evaluators more positively than is true. Bitter ex-patients, who may have been involuntarily dropped from the program, may refuse an interview with treatment personnel or give a falsely negative picture to any outside evaluator. And, unless the outside evaluator guarantees confidentiality from all other parties *including treatment personnel*, the response bias is potentially identical with that in an interview with treatment personnel themselves.

These considerations are not limited to subjective data, because most follow-up studies also collect unverified, self-reported "objective" data on variables like employment, arrest and conviction records, drug use, etc. Because of bias problems in b oth directions--regardless of the research group--concern must be given to externally validating any self-reported data.

Trust and Access. A central problem in the follow-up of drug abuse patients is the location of those patients who have left treatment. Such patients have a history of criminal and anti-social activity and many continue to commit crimes and use illegal drugs after they leave treatment programs.

Treatment personnel may have an easier time locating such patients than outside researchers. They benefit from recognizability and trust that has been built during treatment. Ex-patients may see unfamiliar researchers as potential informers, or worse, disguised law officers. Any unfamiliar face has difficulty gaining access to the addict's door.

A similar problem exists with any kind of process research on the treatment program. While outside personnel may be subject to less bias, they may also have limited access to the inner workings of the therapeutic processes, e.g. therapy groups, intimate dyadic encounters, and so forth.

Expertise. Most treatment personnel are not trained in research methodology and techniques. Moreover, the location of departed ex-patients involves a technology which goes beyond trust. If local administrative or research personnel are not knowledgeable, contracting outside professionals will be the only way to incorporate this expertise. This intervention may

vary, however, from consultation to complete responsibility for design and execution.

Experimental Control. In most clinical situations, control of relevant variables in a true experimental design is difficult. Somewhat less rigorous but nevertheless useful quasi-experimental designs are discussed by Campbell (2), in a significant article reviewing evaluative research of innovative programs.

The more useful research designs involve some degree of experimental control, and that is likely to be more possible with treatment, administrative, or local research personnel in control. Outside evaluators rarely become involved in true experimental designs, e.g. randomization procedures. The approval of those in supervisory control is usually not sufficient for experimental manipulation; their active involvement and responsibility is essential. The most benevolent situation for experimental research is, of course, the program designed and planned by researchers. A formidable example in the drug abuse treatment field is the methadone program of Santa Clara County under Dr. Avram Goldstein, the source of considerable experimental research.

A Model for the Synthesis of Personnel Groups

At the Veterans Administration Hospital at Palo Alto, California, we are currently conducting an intensive evaluation of our drug abuse treatment effort, which includes three very different therapeutic communities and a methadone maintenance program. As our eighteen month intake period is ending, we have randomized over 600 patients to the four treatment modalities, and are following up each patient for two years following his admission. Preliminary results of the acceptance of programs to randomized patients were presented at the Fifth National Conference on Methadone Treatment (3).

The design, planning, and execution of this project, which is funded by the National Institute of Mental Health (MH-22853), represents a model for the synthesis of the three described personnel groups. Their involvement in this project are discussed separately below.

1. *The treatment personnel* were involved in the research design and the selection of criteria for evaluation. Thus, outcome results were predetermined to be useful to the programs themselves. Treatment personnel

are *not* utilized in gathering intake data (accomplished during detoxification before transfer to a program), locating ex-patients, or doing follow-up interviews.

2. *Administrative personnel* were involved in the research design, and were instrumental in facilitating the randomization scheme. The project is headed by a staff psychologist not directly attached, responsible, or supervisory to any of the treatment programs.

3. *Outside personnel*, Stanford University employees having no direct line of responsibility to the Veterans Administration, are responsible for the execution of the project, which is funded through Stanford.

Three full time research assistants have offices on the detoxification ward, but have no clinical responsibility to that program. They meet and interview every patient entering the study, and are also responsible for the subsequent follow-up contact. The independence of the research staff and the complete confidentiality of the data is stated verbally and in writing to each patient. In this way, patient responses to the researchers cannot affect their treatment in any way, and are relatively free of such bias. Similarly, confidentiality from all parties including treatment personnel is guaranteed in the follow-up assessment. While this separation from clinical staff is explicit, the research assistants nevertheless interact with the clinical staff and engage in informal discussions with patients. This contact builds a trust and familiarity which facilitates follow-up efforts.

In addition to the full time outside personnel, consultants on special technical problems, including cost-effectiveness accounting and multivariate statistical analysis are employed.

We believe by combining the three principal personnel groups in this manner we have maximized the aforementioned advantages of each. Because the problems of response bias remain regardless of the responsible group, extensive reliability and validity studies of self-reported intake and follow-up data are planned. Validity checks which involve the use of public records for employment and legal activity, urinalysis for drug use, and interviews with family and friends for interpersonal data.

In summary, the most powerful evaluative research may best be accomplished with the integration of various personnel groups, including treatment personnel, local administrators and researchers, and outside professionals, in order to minimize bias, maximize trust, expertise, and experimental control.

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